MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

25378

1. PLACE OF DEATH

County ..... Registration District No. 791 ..... File No. .....

Township ..... Primary Registration District No. 1003 ..... Registered No. 7186

City Sr Louis (No. City Hospital ..... St. ..... Ward)

2. FULL NAME Arthur Lloyd Hagen (HAGEN)

(a) Residence. No. 6454 Virginia Av St. ..... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Oct 4, 1923

7. AGE: Years 4 | Months 9 | Days 5 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Nour

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) Sr Louis
(STATE OR COUNTRY) Missouri

PARENTS

10. NAME OF FATHER William Hagen Sr

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Girard
(STATE OR COUNTRY) Kansas

12. MAIDEN NAME OF MOTHER Esther Jones

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Festus
(STATE OR COUNTRY) Missouri

14. INFORMANT Wm Hagen
(Address) 6454 Virginia

15. FILED JUL 10 1928 19.. Max C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 9 1928

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19....., that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 4 15 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Phosphorus Poisoning

following Swallowing of (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Burned Fireworks (duration) ..... yrs. ..... mos. ..... ds.

174X

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? Accident

8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? Yes 177

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) [signature], M.D.

10/VII, 1928 (Address) Coroner

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Mount Hope

DATE OF BURIAL: 7/12 1928

20. UNDERTAKER: C Hoffmeister U & L Co

ADDRESS: 7814 S. Bdwy

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

THIS IS A PERMANENT RECORD